DDN

Drink and Drugs News
April 2021
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IN IT TOGETHER
Working with couples

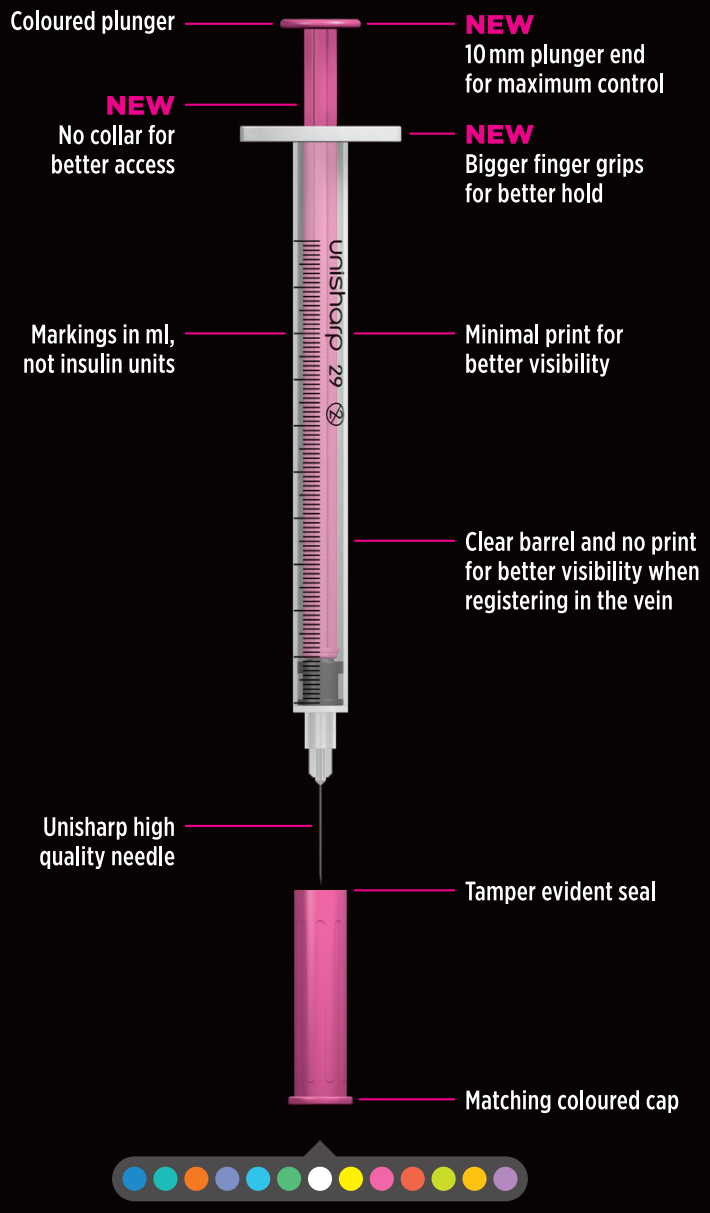
HEP C ELIMINATION
The last miles will be the hardest

EVERYONE IN

UNMISSABLE OPPORTUNITIES FOR LIFE-SAVING HARM REDUCTION

unisharp

Designed for self-injection



EXCHANGE
SUPPLIES
MAKING INJECTING SAFER

DDN

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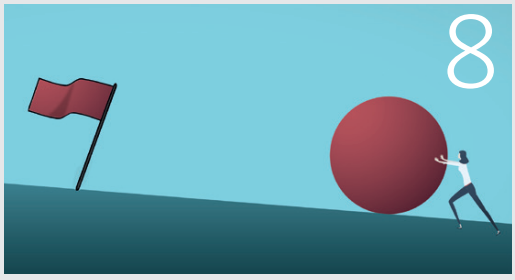


Why the fight against stigma must go up a gear

A brave idea with tangible results

The idea of buying alcohol for people with severe dependence might seem a strange one to many. The outreach team in Bristol (p6) are well enough tuned to harm reduction to know that their life-saving actions during lockdown have opened up many opportunities. It's a brave idea and the tangible results of their initiative speak for themselves.

Practitioners know what works – as do many senior figures in police and criminal justice. On the eve of his retirement, PCC David Jamieson reiterated his plea for change to parliamentarians, backed by a clear set of recommendations that are being shown to save lives. Are politicians appreciating the fact that these measures are supremely cost effective in protecting the public and saving money – as well as the lives of so many vulnerable people? What more can we do to get the message across?

Tackling stigma is a very obvious part of this (p12), and we can all do our bit. It's not just about minding language, but about mutual respect, being wary of making assumptions, and keeping an open mind – from treatment options to considering new ideas. We hope this month's issue gives food for thought and look forward to your views.

Claire Brown, editor
Keep in touch at www.drinkanddrugsnews.com and @DDNmagazine

Urgent funding needed for young people's services, says RCPsych

The Royal College of Psychiatrists (RCPsych) is calling on the government to invest more than £40m in young people's addiction services to 'prevent lifelong addiction'. The number of young people in treatment has fallen by 40 per cent since 2014-15, it says, with funding cut by 37 per cent since 2013-14.

Eight of the nine English regions have made 'real terms cuts', the college's analysis says, with London losing £4.6m, the West Midlands £7.6m and the North West more than £9m, part of an overall total of £26m cut since 2013-14. Meanwhile the number of young people accessing treatment across the period from April to January has dropped from almost 15,000 in 2014-15 to just under 9,000 in 2020-21, although the college acknowledges this year's figure could have been worsened by the pandemic.

Most young people accessing services do so for cannabis use, while almost half have a problem with alcohol – in 2018-19 there were more than 40,000 alcohol-related hospital admissions among the under-24s, over a quarter of which were for mental and behavioural disorders due to alcohol use. RCPsych wants to see £43m of funding for local authorities allocated urgently to 'bring spending on youth addictions services back to at least the 2013-14 level' – equivalent to 2.4 per cent of public health spending.

'These cuts risk condemning a generation of vulnerable young people with drug or alcohol problems to a lifetime of dependence and poor health, or in some cases, an early death,' said vice-chair of RCPsych's addictions faculty, Dr Emily Finch. 'It's completely unsustainable and unbelievably short-sighted. We need to wake up to the fact that money spent on addictions services saves the NHS a whole lot more in the long run, whether that's in A&E or in other mental health services. On top of all this, the pandemic has made a dire situation even worse, as even more young people have been left unable to access services.'

'These cuts [are] completely unsustainable and unbelievably short-sighted.'
DR EMILY FINCH

Smokers require care a decade earlier

SMOKERS IN ENGLAND WILL NEED HELP WITH EVERYDAY TASKS including 'dressing, walking across a room and using the toilet' ten years earlier on average, according to a report from ASH. Around 1.5m people need care by the age of 63 as a result of their smoking, says *The cost of smoking to the social care system*. While current smokers and people who quit within the last ten years are more likely to need support with all activities than people who have never smoked, they are 'particularly likely to need support with relatively time consuming, fundamental activities', says the report, such as help with dressing and undressing, having a bath or shower, or getting in and out of bed.

The annual cost to the country's budget for home and residential adult care is around £1.2bn, the document adds, with more than 100,000 people thought to be receiving local authority-funded care as a result of smoking – 17,500 in residential care and 85,000 in their own homes. Smoking remains England's leading cause of premature and preventable death, killing almost 75,000 people in 2019. 'For every person killed by smoking, at least another 30 are estimated to be living with serious smoking-related disease and disability,' says ASH.

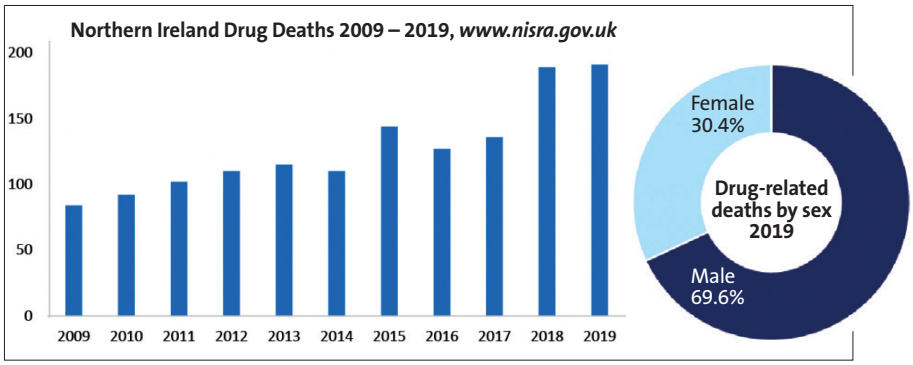
Report at ash.org.uk

Bold policies needed

BOLD POLICIES SUCH AS DECRIMINALISATION AND CONSUMPTION ROOMS are needed to help reduce Scotland's record rates of drug-related deaths, says a report from the Royal College of Physicians of Edinburgh. Among the document's recommendations are for the Scottish and UK governments to give 'evidence-based consideration' to the decriminalisation of drug possession, and for politicians to work together constructively and listen to the views of those on the frontline. 'The political debate on Scotland's drug deaths problem has been, at times, unhelpful,' it states, and stresses that cross-party consensus is essential, along with action to address socioeconomic factors such as employment, housing and education.

Meanwhile, Northern Ireland has recorded its highest ever number of drug-related deaths, with 2019's figure of 191 more than double the figure from a decade ago. Almost half of the fatalities were of men aged between 25 and 44, with almost all classed as resulting from drug misuse. People living in the most deprived areas were five times more likely to die a drug-related death than those in the least deprived.

Drug deaths in Scotland: an increasingly medical problem at www.rcpe.ac.uk; Drug-related deaths in Northern Ireland, 2009-2019 at www.nisra.gov.uk



Homelessness 'substantially' increases BBV risk for people who inject drugs

Homelessness and unstable housing are associated with a 'substantial' increase in acquisition risk for both HIV and hepatitis C among people who inject drugs, according to research by the University of Bristol. Recent homelessness or unstable living circumstances meant a 55 per cent increase in HIV risk and 65 per cent for hep C risk, researchers found.

Worldwide, an estimated 22 per cent of people who inject drugs reported experiencing homelessness or unstable housing within the last year, with the figure for England standing at 42 per cent. Of the estimated 15.6m people globally who inject drugs, more than one in six are thought to be infected with HIV and more than half with hep C. The study, which was carried out by the University of Bristol's NIHR Health Projection Research Unit in Behavioural Sciences and published in *Lancet Public Health*, is the first systematic review and meta-analysis of the link between BBV risk and homelessness, and combines data from 45 previous studies.

Homelessness and unstable housing mean people are less likely to access both harm reduction measures such as needle exchange or substitute medication and HIV or hep C treatment – they are also more likely to have recently been in prison and to engage in higher-risk injecting behaviour. According to the Homeless Link charity, 30 per cent of the homeless population report last-month use of heroin. The response to the COVID-19 pandemic – which saw many countries quickly provide safe and secure housing for homeless people – demonstrates that 'dramatic, if only temporary, changes are possible if there is the political will', the report states. 'Our study highlights the overlapping bio-social problems that worsen health inequalities among homeless people who inject drugs,' said lead author Chiedozie Arum. 'Expanding access to prevention and treatment services and improving housing provision for this population should be prioritised.'

> 'The response to the COVID-19 pandemic... demonstrates that dramatic, if only temporary, changes are possible if there is the political will.'

Homelessness, unstable housing and risk of HIV and hepatitis C virus acquisition among people who inject drugs at www.thelancet.com/journals/lanpub/home

GHB RECLASSIFIED

GHB AND RELATED SUBSTANCES ARE TO BE RECLASSIFIED from class C to class B, the home secretary has confirmed. The ACMD recommended in a report last year that GHB, GBL and related compound 1,4-BD should be reclassified, after the government requested a review following high profile cases in which GHB had been used to facilitate rapes and murders (*DDN*, December/January, page 5). 'It is clear from the report that the harms of GHB and related substances require a broad response,' wrote Priti Patel in a letter to ACMD chair Professor Owen Bowden-Jones.

'Big blow' to health

THE CHANCELLOR'S DECISION TO FREEZE ALCOHOL DUTIES for the second year running represents a 'huge blow for the health of our population', says the Alcohol Health Alliance. Charities had been calling on the government to increase duties to help tackle rising rates of alcohol-related deaths – provisional ONS data for the first nine months of last year show 5,460 deaths related to alcohol-specific causes, up more than 16 per cent on the same period in 2019 (*DDN*, March, page 5).

'Since the start of the COVID-19 pandemic, deaths caused by alcohol have hit a new record high in England and Wales and high-risk drinking increased by almost 90 per cent between February and September last year,' said alliance chair Professor Sir Ian Gilmore. 'Alcohol treatment services are on their knees whilst off-trade alcohol sales have hit new heights.'

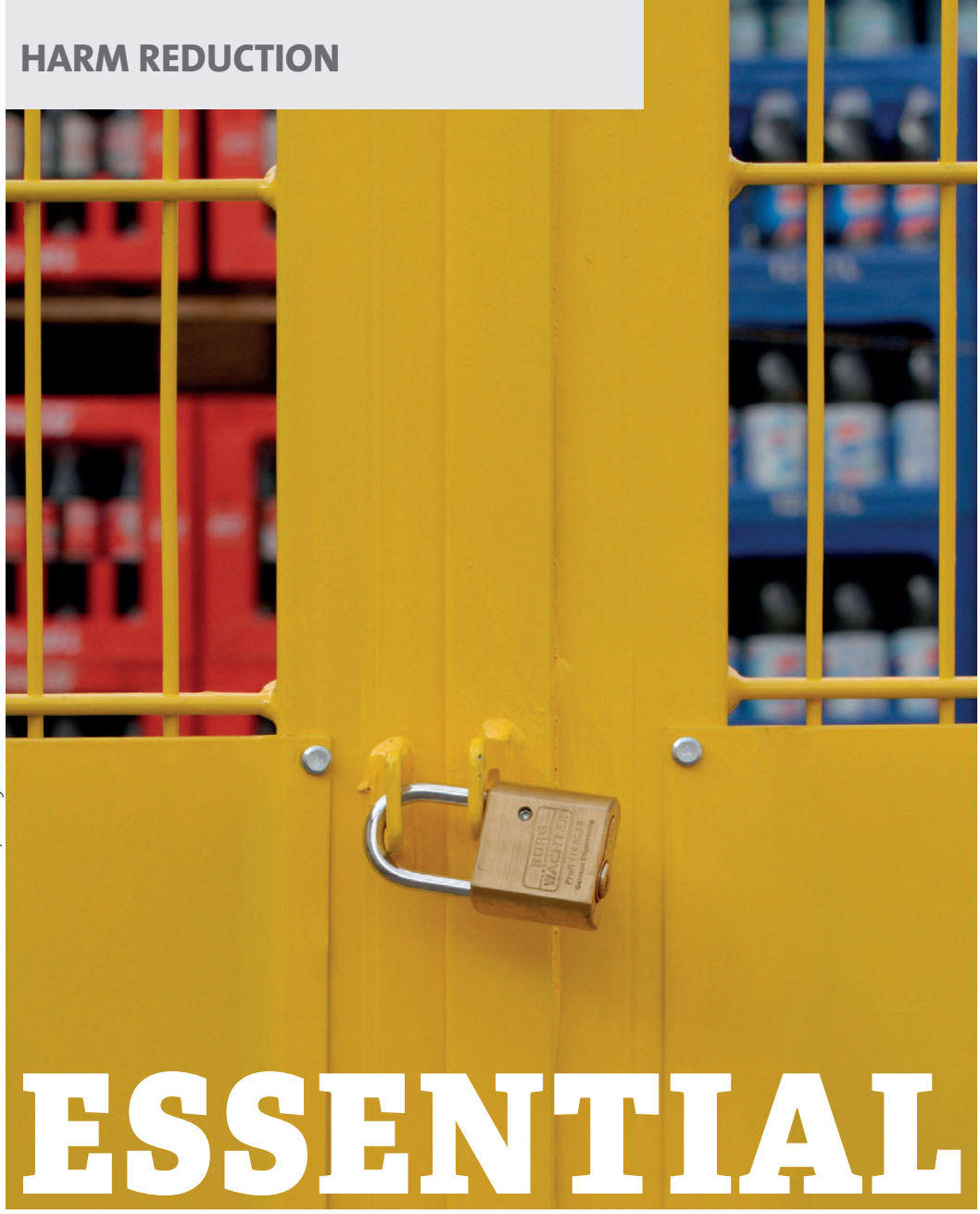
> 'Alcohol treatment services are on their knees whilst off-trade alcohol sales have hit new heights.'
>
> PROFESSOR SIR IAN GILMORE

Local News

TIME TO TALK
Talking Together is a new patient-led support group for people who are HIV positive set up by Kent Community Health NHS Foundation Trust after many reported feeling alone and isolated. 'Some said staff at our clinics were the only people who knew they were HIV positive – they hadn't felt able to tell anyone else,' said project manager Juliette.
Pictured: Steve Bamford, HIV peer support group

SPECIALIST SUPPORT
A specialist drug and mental health support hub for 18 to 25-year-olds under probation supervision will launch in July in Newham, east London. The £3m pilot scheme, which will run until 2023, has been developed by Newham Probation Office and MOPAC.

SOCIAL SERVICE
Two new projects to help people with a history of substance issues to secure a job in social care have been announced by SDF. More than 80 per cent of those graduating from SDF's paid employment programme go on to secure a job 'in either addiction services or wider social care', said senior development officer Colin Pomeroy.
www.sdf.org.uk/jobs



Hartmut Schmidt / Alamy

ESSENTIAL PURCHASES

Buying alcohol for people with severe dependence during lockdown in Bristol has been a lifesaver, says **Rachel Ayres**

On 26 March 2020 our city streets changed dramatically. Shops shut overnight, people went home and the world retreated. Bristol's outreach workers became concerned at the speed with which vulnerably housed or homeless people with hazardous levels of alcohol consumption were catapulted into withdrawal, and unable to meet their drinking needs in the usual ways – nowhere to beg, shop or shoplift. As services retreated, retail outlets vanished and social distancing was enforced, people were left high and dry.

In Bristol, the government's Everyone In scheme saw 427 people moved into emergency accommodation. Needs assessments indicated 35 requiring immediate alcohol treatment, 115 needing drug treatment and 24 with concurrent drug and alcohol dependency, and by April outpatient and inpatient detox facilities had closed, and GP appointments dried up. Dr Mike Taylor from Bristol's Homeless Health Service and Dr Ben Watson from the ROADS alcohol and drug treatment service agreed that medically assisted detox within the new accommodations could not be managed safely – elective alcohol detoxification would not be possible for the foreseeable future and emergency admissions for delirium tremens would increase.

In an attempt to reduce the inevitable impacts, a simple alcohol harm reduction information sheet produced by the South London and Maudsley NHS Foundation Trust was adapted and distributed across the city via all available channels. However, severely dependent people remained chronically unwell, and some outreach workers confided to buying alcohol in small quantities as a life-preserving intervention. Something had to change. A donation of £5,000 to Bristol Drugs Project and a decision was made to provide the essential items needed to enable 'at risk' individuals to follow the harm reduction advice – to not stop drinking.

Two experienced outreach workers led the Essential Items Project – Darlene Wheeler from the Bristol Street Intervention Service (SIS) and Nicky Auguste, diverse communities link worker from BDP. The idea was to identify the highest risk guests from the Everyone In accommodation, and provide the alcohol needed to prevent precipitous withdrawals during lockdown.

Something more surprising emerged, however – a small cohort of people whose severe dependence on alcohol had previously been a barrier to secure accommodation found themselves with a safe place to live, round-the-clock support, food, and their alcohol needs met. Strong relationships with project workers and hostel staff, and reliable supplies of alcohol fostered autonomy and a desire for change, and the unexpected outcome was successful alcohol detox for 12-13 project participants.

The principles of the project were to buy people's alcohol of choice and to use person-centred and trauma-informed approaches and the usual harm reduction tools to promote stable drinking

and support safe reductions if requested. With clinical support from ROADS alcohol specialist Dr Janine Hale-Brown, Darlene and Nicky planned stabilisation regimes for hotel guests who were drinking 50-plus units per day. Darlene's caseload included people previously known to her from street outreach work and Nicky's caseload remained within his diverse communities remit, supporting people from Poland, Lithuania, and Italy, four of whom required a translator.

All the work was face-to-face and mainly outdoors – on walks and in parks – and often opportunistic. Participants completed alcohol diaries and devised SMART goals to map reductions. 'Pros and cons of using' and 'delay, distract and decide' ITEP maps kept focus and built refusal techniques, while participants recognised their opportunity for change and wanted to detox.

Where possible, alcohol was stored at the accommodation, date-labelled and available when requested. Prompt supervisory responses from clinical leads kept detoxes safe and on track and Darlene and Nicky worked flexibly, often meeting people several times a week. They provided an individualised and self-directed approach to reductions, pausing when people felt the need, speeding up during periods of confidence.

Two experienced outreach workers led the Essential Items Project – Darlene Wheeler (left) from the Bristol Street Intervention Service (SIS) and Nicky Auguste (right – pictured with Jan in the hat), diverse communities link worker from BDP. The idea was to identify the highest risk guests from the Everyone In accommodation, and provide the alcohol needed to prevent precipitous withdrawals during lockdown.

'I tried detox many times on my own, like Sisyphus, rolling the stone up the mountain. I was so sick at the hotel that staff helped me drink to stop me dying.'

There were real challenges. Purchasing large amounts of the required brand of alcohol week after week required tenacity as shops were often shut and purchases sometimes rationed.

Some innovative provision of alcohol was required – James was drinking 12 litres of 5 per cent cider per day, and he couldn't drink enough volume to reduce tremors when Nicky met him. By swapping to an alternative brand at 8.2 per cent he halved his fluid intake and could manage his withdrawal symptoms, fully engage with support and start a planned reduction.

Conversely, by the time Ivor had reduced to six cans of 7.5 per cent he was finding the reduced volume difficult – step one was to switch to cans containing 5 per cent alcohol and then to slowly increase the amount of water and soft drinks as the alcohol volume came down. Safety, security and a reduction in alcohol use also gave people space to resolve other barriers to recovery. One 28-year-old man discovered he had settled status and recourse to public funds. With housing benefit in place, onward referral for housing was made and he is now abstinent with his own tenancy.

Despite the challenges, outcomes were impressive. Twelve to 13 detoxed completely – eight of these finished with a brief chlodiazepoxide prescription from clinical leads, two went on to an inpatient detox and two reduced slowly without medication. One person withdrew from the project.

The cost of the project was £8,300. Keyworker time was estimated at £3,300 plus the essential items budget, resulting in a spend of £638 per person – specialist clinical supervision and detox costs are not included here. Each person received an average of 17 separate visits totalling 12.5 hours of harm reduction interventions, with the workers' involvement with individuals ranging from four to 13 weeks, depending on the speed of alcohol reductions.

The Essential Items Project delivered life-saving harm reduction. It also offered an alternative to people with multiple previous attempts of medically assisted detoxification.

While the long-term outcomes for all of this small group are not known, Nicky met Jan for a 'reunion' in February 2021. Six months after detoxing he was still abstinent, attending Polish AA twice weekly and living in a shared house. Jan had been alcohol dependent for more than 20 years, and reflecting on his detox and subsequent abstinence he said, 'I tried detox many times on my own, like Sisyphus, rolling the stone up the mountain. I was so sick at the hotel that staff helped me drink to stop me dying. Everyone was looking out for me and helping me control my drinking, and everyone was so friendly. Now I'm happy, I feel my power back. I still have good and bad thoughts in my head. I go to Polish AA, I have a room in a friendly house, I have my papers. I am alive.'

Nicky felt the project allowed him to work at Jan's pace – 'I had time and resources to work intensively with Jan, to get to know him and build trust,' he said. 'I appreciated his commitment and rock-solid desire to detox, through all the ups and downs. In addition to providing his alcohol and working out a reduction plan together we found English classes, and Polish AA.'

Asked how easy it was to buy the vast quantities of alcohol needed for thirteen project participants on a daily basis, at the height of lockdown Darlene and Nicky both laughed – 'it was a challenge, lots of hunting, but we got it down to a fine art'. But when it came to job satisfaction, they both feel this was a bold initiative, high on reward for those they supported and good to feel effective as workers during such a difficult time.

Rachel Ayres is policy and quality development worker at Bristol Drugs Project

Organisations and peers have risen admirably to the challenge of continuing the hep C elimination fight during the COVID crisis, heard delegates at LJWG's annual conference. But the final steps towards elimination will be the hardest. **DDN** reports

'The last year has been incredibly tough for everyone, but it's been inspiring to see how different organisations have come together on this issue despite the pandemic,' London mayor Sadiq Khan told the London Joint Working Group on Substance Use and Hepatitis C's (LJWG) annual conference – an online event this year. Just one example had been the 'enormously successful initiative to offer blood-borne virus testing to homeless people housed as part of our Everyone In scheme (*DDN*, September 2020, page 6), which spread awareness about the virus and the treatments available'.

STORES OF HOPE

While the situation was still 'incredibly challenging', said event chair Vicky Hobart – the Greater London Authority's (GLA) head of health – there were 'real stories of hope' in what could be achieved with effective joint working. The *Routemap to eliminating hepatitis C in London* (DDN, May 2020, page 10) steering group had continued to meet, while the initiative to roll out BBV testing for homeless populations in temporary accommodation had been 'a flagship moment'.

More than 1,000 people had been tested – 7 per cent with active infections – and more than 40 had already started treatment, she said, with partners now looking at how this approach could be applied to other settings. Future priorities would include multi-morbidity testing and diagnosis, opportunities for co-commissioning and 'real efforts and pressure towards faster testing and turnaround of results'.

WORLD LEADER

London had been a world leader in its response to hep C, chief executive of the World Hepatitis Alliance, Cary James, told the conference. The alliance had launched a survey to measure the impact of the COVID crisis, with responses from more than 30 countries. 'Just about everyone said that their services had been interrupted, but everyone was talking about how they'd been working to overcome these barriers – that shift was really inspiring to see.'

While Eastern Europe had reported significant problems in terms of people being able to access services, it was far less of an issue in the west, he said. 'People and organisations in London really were leaders in that. Even before the COVID crisis, London was a leader globally in terms of its response to hepatitis C – the routemap being launched was a very strong indication of that – and what's happened since COVID has hit has really reinforced it. We always hold up the great work being done here, especially around peer-to-peer services and the huge role community has in making elimination a reality. It's something that's really helping to educate the world.'

Globally, however, stigma remained a significant challenge, he said. 'There's generally a lack of compassion for people living with viral hepatitis. On paper, hepatitis elimination is such a no-brainer, but there's a lack of empathy from the people who have to pick up that elimination plan and give it to their finance minister to pay for it. That's one of the biggest challenges we face.'

DEVASTATING IMPACT

Public Health England (PHE) was about to publish a document showing the pandemic's 'devastating impact' on testing, said PHE consultant epidemiologist Dr Emily Phipps. 'We saw a huge drop-off, particularly in the early days of lockdown.' While this was the case across all settings, drug services had been hardest hit, and despite immense efforts from the Operational Delivery Networks (ODNs) treatment numbers had also fallen. 'But without those efforts they really would be rock-bottom – so the ODNs really are to be commended'.

In terms of the impact on people who inject drugs, there had also been concerns around people being able to access injecting equipment and substitute medication, as well as 'reported changes in risk behaviours', she said, with one in six people surveyed by PHE reporting injecting more frequently.

'But despite all the doom and gloom we're still seeing a reduction in cases, and there are some very exciting numbers coming out of London in particular,' she continued. 'But as we come closer to elimination it's going to become even harder to identify people remaining to be tested and treated,' and optimising available data

www.london.gov.uk

'The last year has been incredibly tough for everyone, but it's been inspiring to see how different organisations have come together on this issue despite the pandemic.'
Sadiq Khan

HARD MILES

Jozef Micic / dreamstime.com

would be key to this. 'There are still people in London who don't know about direct-acting antivirals – not just patients, but also professionals including GPs – so there's definitely communications work to be done as well.'

REVOLUTIONARY STRATEGY

While the events of the last year had tested everyone to the limit, said clinical lead of the pan-London street outreach Find & Treat service, Dr Al Story, the Everyone In strategy had been 'quite revolutionary – it was an amazing achievement to get so many people off the street and into accommodation.' Rough sleeping had been increasing in London for almost a decade and had become 'one of those problems that people had been conceiving as intractable and impossible – but it's amazing what can be done with the political commitment'.

Having thousands of people in accommodation represented 'amazing opportunity', he stated. 'We were given the green light to seize this opportunity and offer a full BBV screen to as many people as we could', in partnership with a number of other organisations. The model was peer-led diagnosis and treatment initiation, ideally within a day – 'and the vast majority of people we've engaged with have started treatment within 48-72 hours. We've been trying to take what was once a war of attrition – multiple appointments – and squash it into an outreach encounter that can be done in literally a few hours.'

In terms of the data, what was most striking was the 'staggering number' – almost half – who had never been tested, he stressed. 'We know the population we work with can present some unique challenges but we've been delivering tuberculosis services to this same population for many, many years and we achieve outcomes that are better than in the general population.' The team had also been expanding its work to the street sex worker population, he said. 'So far just 30 women have been screened but the findings are quite mind-blowing. A very high proportion are homeless, a quarter are rough sleeping and almost half are currently injecting. There's a very high undetected reservoir of hep C in that population, and a great opportunity to take services to people.'

COVID had 'blown a greater wedge in what were already quite marked health inequalities', he stated. 'We've seen an increase in rough sleepers, and many people new to the streets are coming out of job loss and loss of housing tenure. And I think we haven't seen the half of this yet.' On a more optimistic note, the use of peers offered 'an amazing opportunity', he told the conference. 'They're not corrupted by medical training, they remain completely open-minded and agnostic and responsive to patients' needs, and I think with the right tools and support they can lead the revolution here.'

NEW MODELS

One example was shared by the Hepatitis C Trust's senior peer support lead, Imran Shaukat. 'When COVID hit we had to adopt to a completely new model,' he said. 'A lot of clinical staff were deployed to ICU wards, meaning the charity had issues keeping the service going, so all the peers got together and almost reinvented the service. We absolutely adapted – we started doing the medication delivery and keeping in touch with people on the phone – and even though the pandemic was psychologically and physically challenging the silver lining was that we were working very closely with our partner organisations and found that co-working was just the way forward. It just naturally happened, and that relationship's continued. That's the key to elimination – everyone coming together under one goal.'

Peers were also able to engage very effectively with people not in drug services, he pointed out. 'But my worry is that as the numbers are going down resources will start to be pulled back and leave us open to further spikes of the virus.'

'The elimination agenda is a great objective, but these will be hard miles – the last few cases are the hardest,' said Story. 'From a co-commissioning perspective there's real safety in numbers here – it makes great economic and practical and epidemiological sense to join up. And, most importantly, it makes sense for patients.' **DDN**

'There's a concept that's difficult to process, and it's that COVID isn't going anywhere,' warned Dr Emily Phipps. 'It's here to stay and there's going to be a long road back to any kind of normality. Instead of putting things off we should be looking at how we can work in this new context – there's been some really innovative new delivery models that have come out of the pandemic, including lots more outreach work and delivering needles and syringes by post. But what's really important to emphasise is the need to really evaluate these new methods so we can understand the impact.' This was particularly the case with people who might have difficulty accessing services because they were digitally excluded, she stressed.

HEPATITIS C THE CHALLENGE TO GPS

hepctrust.org.uk

'Join the party, save a life – test someone for hep C... There's an enormous amount of work we can do together.'

PROF GRAHAM FOSTER

'We need to find people with hepatitis C who have tested positive but not been treated,' Prof Graham Foster, professor of hepatology at Barts Health told GPs. He was speaking at the 25th RCGP and SMMGP Managing Drug and Alcohol Problems in Primary Care conference, held online. There were people registered as having the virus, who were not being offered treatment, he said. 'Look through your practice records and find them.'

Others might be harder to find, such as people who had injected drugs in the past and had long put the lifestyle behind them. Look for the risk-takers – the 'ex-drug users who are hiding away in plain sight', he said. 'Anyone who has ever injected drugs is at high risk of HCV.'

With treatment options better than ever before, the cure rate was 96 or 97 per cent. The NHS was 'committed to elimination' with a £200m a year budget, and he called on GPs to be fully involved in the 'fast and aggressive' programme.

Catching and curing early was important – the younger the patient, the better the chances of a good outcome, before liver scarring, cirrhosis and cancer, and there had never been a better time for treatment. Medications produced by three different pharmaceutical companies not only tackled the different strains (genotypes) of hep C – the competition between manufacturers had driven the price down, so 'we really can afford for everyone to be treated'.

'Join the party', 'save a life – test someone for hep C', he urged. With financial incentives for GPs to find and treat patients the invitation was viable as well as aspirational. 'We will roll out the red carpet for enthusiasts,' he told GPs. 'There's an enormous amount of work we can do together.'

More reports from the conference in our May issue

CLERO

STRENGTH IN NUMBERS

Stuart Green launches a series of regular columns to develop a lived experience recovery movement

This month The College of Lived Experience Recovery Organisations (CLERO) starts a series of bimonthly columns. Our aim is to keep all Lived Experience Recovery Organisations (LEROs) up to date with developments, activities and milestones to support the growth and credibility of the LERO movement in the UK.

We are establishing a structure with three tiers:

Tier 1 Coordination and oversight group of around 12 members

Tier 2 Lived Experience Recovery Organisations, each represented by one spokesperson

Tier 3 Professionals, commissioners, associated groups and all those who want to support the College of LEROs

'LEROs have a much-needed role to fulfil ... through the voices of lived experience.'

We've currently had 45 applications to join from Lived Experience Recovery Organisations to date. The rationale for joining tier 2 is the opportunity to co-produce a shared evidence base, access funding opportunities, develop evidence-based practice, and establish quality standards to promote local and national recognition.

Tier 2 membership also brings the unique ability to connect with other LEROs through events and press releases, and to build connections, support networks and knowledge about innovative practice. Our next online event for CLERO tier 2 is on 23 April and will be facilitated once more by our friends Peter and Yvonne from Axiom News Events. To join this coalition of LEROs on our journey please follow this link for membership: *https://forms.gle/czYLpBouxHQMWKnj8*

The CLERO has secured a grant from the Big Lottery to support our programme of work and build an evidence base around LEROs across the country. One of the initial tasks for the CLERO coalition is mapping the strengths and innovations of LEROs by building a research network of lived experience researchers and initiating a process to develop quality standards.

LEROs have a much-needed role to fulfil in the Recovery Orientated System of Care. Through the voices of lived experience, the coalition hopes to influence and shape the local and national treatment and recovery landscape for people who suffer from addiction issues. The proposed approach has been designed by members of LEROs in order to create a local, regional and national voice that can support quality standards, evidence good care in formal treatment settings and contribute to policies and decisions relating to service provision.

We are also delighted to announce that William White has kindly agreed to be patron of CLERO.

Stuart Green, CLERO member (Aspire service manager, Doncaster)

HAVE YOUR SAY
Write to the editor and get it off your chest
claire@cjwellings.com

WHY I DIDN'T LEAVE

In response to 'Why doesn't she just leave', *DDN* March, p8:

I was in a violent relationship. At one point he nearly strangled me, but I wanted to die, I had had enough of him hitting and bullying me. But, this was a man who I loved very much and when he wasn't punching hell out of me he was the nicest most generous man on earth.

I stayed because I loved him, but then the beatings got more and more – but you know what, I still loved him and I still wanted to stay. I had to leave as he became too violent and him nearly strangling me for drug and gambling money was the last straw. But then I went through being scared of seeing him, then if I saw him I wanted to kill him, then I just didn't care.

So... I stayed longer than I should have because the man I met and wanted to be with I loved, but he changed in time because his needs changed, he needed money for drugs and gambling.

Name and address supplied

TRAUMA AWARE

I read with interest the March issue with a focus on childhood trauma. I wanted to let you know about the work we have been doing in Bristol around this, and wider trauma- and adversity-informed practice. While childhood or developmental trauma is important and prevalent

'...the beatings got more and more – but you know what, I still loved him and I still wanted to stay.'

in our client group, it can be helpful to think more broadly about experiences of trauma and adversity through the lifespan, considering how service users can often be repeatedly exposed to traumatising situations through their lives. Each experience compounds the previous ones, making it harder and harder to feel hopeful about the future or for change.

We run a training day for all staff, volunteers and peer mentors offering an introduction to trauma and adversity informed practice and have trained over 100 drug and alcohol staff in this so far. We also offer evidence-based psychological interventions for trauma to our service users, both group and one-to-one based. We provide reflective practice sessions to groups of practitioners across the system, providing people with a chance to think about the impact of working with traumatised clients and how to avoid re-traumatisation through our service delivery.

I would be really keen to connect with other practitioners working in the same way across the country and to share information with others about any aspect of what we're doing.

Dr Sarah Stacey, clinical psychologist, by email

DDN welcomes all your comments. Please email the editor, **claire@cjwellings.com**, join any of the conversations on our Facebook page, or send letters to DDN, CJ Wellings Ltd, Romney House, School Road, Ashford, Kent TN27 0LT. Longer comments and letters may be edited for space or clarity.

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LOSING OUR VOICE

A failure to have effective independent SU forums in place is having a detrimental impact, says **Vincent Yewlett**

The people who use services need to be represented independently by service user forums run by service users. I have been chairing for nearly five years regionally and three years nationally. In my own experience, and other SUs' experiences, meaningful co-production has not been included throughout two recommissioning processes. Clear engagement with the people who are unable to access services has not been considered when recommissioning new services. As far as I can see, this is in the contracts of the area planning board (APB) and the Welsh Government (WG), but it has not been done.

As a result of having ineffective SU forums, the communities are not getting reached and the information is not being collected that is needed for effective recommissioning processes.

This also impacts on many other areas including the harm reduction strategy. The only way to see if this strategy is implemented into all commissioned services is through SU forums, as no commissioned services would volunteer to tell the APB or WG if that service was failing in a particular area. As I have been part of SU forums for some time and have attended every meeting, I can comment on this from experience.

SU are the most effective connections with people who are not currently in services. If the effective tool of the SU forums is not able to help services improve, it also leaves people who use services with no voice, nowhere to take current issues, problems or positive experiences of treatment.

This is putting people and the harm reduction strategy at risk, and leaving people who use services with no support or safety net when issues arise. It's also seriously affecting the effectiveness of the recommissioning processes which aim to create better services to help the public and communities reduce harm and save lives. When done effectively, service user involvement can take the strain off other services like criminal justice, social services and the NHS. It helps the homeless population and reduces the crime rate.

The SU forums were created by APB and WG specifically for these purposes and it's in the APB and WG contract. The APB and WG are commissioned to create better services, make sure the harm reduction strategy is implemented in the commissioned services effectively and to check that when the recommissioning of services is complete, it's working for SU in the community. They are also commissioned to collect the views of SU, which in Cardiff and the Vale has not been done in an effective way.

Vincent Yewlett is regional and national SU chair for Wales, email voiceforthecommunity@outlook.com

LOADED LANGUAGE

Stigmatising language doesn't have to be obvious to do harm, says **Liam Ward**

At Phoenix Futures we have been thinking a lot about stigma, rights and treatment access, and we hope these will be key themes in Dame Carole Black's forthcoming review. There is a sense that we could be on the verge of a period of positive change. But that change can only be maintained if we reflect on some key underlying structural and societal considerations.

Phoenix have been highly vocal on the issues of access to detox and residential services. Over 50 per cent of English local authorities refer fewer than five people a year to rehab, and there is zero access in more and more local authority areas. We know the 'postcode lottery' is unfair, but in some parts of the country there is total exclusion from NICE-approved, clinical guideline-recommended treatment.

We are optimistic that the coming year will see a strong upturn in the number of rehab placements across the country, made possible by the government's commitment to invest a further £80m in drug services in addition to the existing budgets available to each local authority. The sector has received this news favourably on the whole, but there is a collective appreciation that this represents a good start rather than a solution. The funding falls far short of the £900m across three years reportedly recommended by Dame Carol Black, and represents only half of the £160m cut from drug treatment services in the last decade (DDN, February, page 4).

The spending review in which the new funding was announced took the cautious approach of outlining the spending for just one year in light of the ongoing pandemic. It is hoped that a more robust commitment over a prolonged period will follow to give the sector some security when putting long-term plans in place.

REHAB CAN BE FUN DESPITE BEING TOUGH

Behind the stigmatising views that often exist lie groups of happy, positive and motivated people working hard and committed to overcoming a multitude of problems. Photos courtesy of Phoenix Wirral residential rehab.

There is, rightly, a focus on stigmatising language in the sector. Language frames the way we think, and while non-judgemental language is important to reduce stigma, it's equally important that we consider the subtle use of language that disempowers, judges and marginalises the people who use our services. Here are some of the common arguments we hear to justify the de-funding of residential services:

THERE'S NO DEMAND

This simply isn't true. When we speak to people desperate for rehab, we're told they have had to 'fight' and 'beg' to even be considered for a placement. We know the lack of demand is due to lack of awareness, and that is understandable – why would frontline treatment staff make people aware of a treatment option that isn't funded? The 'no demand' argument places the blame firmly on the people seeking treatment. It sounds like a simple statement, it passes in conversation as if it offers some form of insight, but it is just blatant victim blaming.

REHAB'S TOO EXPENSIVE

People with multiple needs require more comprehensive treatment – this is true in almost all forms of healthcare. The 'too expensive' argument is nothing more than a moral judgement and the subtle implication is that some people are worth more than others.

WE CAN'T PUT EVERYONE IN REHAB

This is one we hear often, and often where there is no suggestion that rehab is for everyone. Behind it is a classic use of passive language that creates an image of people waiting to be put somewhere, like pieces on a chess board.

REHAB IS NOT RIGHT FOR SOME PEOPLE

The UK clinical drug treatment guidelines make it clear who rehab is most likely to be suitable for, and this statement deflects from the reality of rehab being underutilised by subtly implying that the treatment on offer would be ineffective for those who miss out anyway.

REHAB PROVIDERS SHOULD DO MORE TO MARKET THEIR SERVICES TO FUNDERS

A seemingly innocuous statement, but behind it is the implication that

defunding is always someone else's problem and not a systemic issue.

All these statements feed a narrative that addiction is fixed, that addiction is a choice, that people can't or don't want to get better, that people are passive and helpless. The combined message is 'it's your fault that you are not well and you are not worthy of help'. If we are to improve treatment access for people with multiple health and social disadvantages we need to confront this subtle stigma-driven language. We need to return to the simplest of concepts, namely that people should be made aware of all treatment options and that health is a human right. The NHS was on the principle that good quality healthcare should be accessible regardless of wealth, but people with mental health and addiction treatment needs are still waiting for that to ring true.

The continued underfunding of the sector means that every year more and more people are excluded from rehab. If we are to make the most of the possibility of a genuine end to austerity for the treatment sector we must address the subtle stigma that shames and blames people seeking help, and move on from a funding-led approach, not just to a demand-led approach, but to a rights-led approach to healthcare. The Care Act, Equality Act and Human Rights Act offer rights to people with mental health and addiction treatment needs, and we sincerely hope that the Dame Carole Black report will support the upholding of those rights.

Liam Ward is residential marketing manager at Phoenix Futures

SETTING THE TONE

Can we guide the media towards more responsible language, asked Adfam in an event that brought together journalists and people with lived experience

'Language is systemic in reinforcing stigma,' said Adfam's chief executive Vivienne Evans, introducing 'Reporting of substance', an online discussion on stigma and language. The family support charity organised the event to help feed into developing media guidelines, and it involved journalists, policymakers, and people with lived experience who gave informative insights from their engagement with the media.

People were too often defined by their activities in the media – 'a drug addict' or a 'junkie' instead of a mother or a son, said Harry Shapiro, director of DrugWise. As the main source of information for most people, the media had a responsibility – but it could reinforce existing values and beliefs and serve up scapegoats. Through the vampire images of heroin users from the 1920s, the *Reefer Madness* and *Cocaine Fiends* films of the 1930s, and the political campaigns focusing on drug use as a moral weakness, there was an individual pathology narrative that hadn't changed much since Victorian times. The public were led to ask, 'Why should we fund a lifestyle choice?'

The key skill for journalists should be to listen without judgement and preserve dignity, said Sharon Frew, chief reporter of *STV News*. It was important for media to honour promises, such as only using first names and selecting appropriate pictures that were sympathetic to the story, rather than sensationalising it. 'Let people tell their stories in their words, as that's where the power is,' added Karin Goodwin, journalist for *The Ferret*.

Dani Carmichael from the Scottish Recovery Consortium was frustrated that there wasn't a standard to hold journalists to. 'I contacted the NUJ and they said there was one in the pipeline,' she said. There was a guide on responsible reporting on mental health and death by suicide that could be adapted to apply to drug use and recovery, she suggested. With Rebecca Bradley of Scottish Families, she had conducted a thematic analysis of news articles and reports and an online survey to both of their communities and realised the work needed to change from stigmatising to empathetic language. Even useful information was being lost behind the language barrier.

It was an uncomfortable subject – not least because we are part of the problem, said Austin Smith of the Scottish Drugs Forum. People needed to understand that drug use was not a moral failing, and the word 'addict' was disempowering when used dismissively by the media, 'as if that is all you need to know about someone'.

Rod Anderson spoke for many who had had an uncomfortable experience when sharing his story with the media. Having been at ease with the interviewer, he was disappointed by the end result and the language used in the article, which had focused more on his addiction than his recovery. 'I felt I lost control of the narrative,' he said.

'When telling your story you have to own your own narrative and never be afraid of asking for copy approval,' advised Camilla Tominey of the *Daily Telegraph*. 'Journalists are lucky to speak to you and have a chance to share your story.'

DDN contributed to the debate, agreeing that dignity and respect were paramount. 'We try to avoid labels, but sometimes it's hard to do,' said Claire Brown, editor. 'Someone writes about their own experience and talks about themselves as an addict, an alcoholic, with a struggle to become clean. Who are we to redefine them if they're talking in the first person?' Context was as important as language, making sure the published version was authentic to the contributor's voice.

'There is an individual pathology narrative that hasn't changed much since Victorian times. The public are led to ask, "Why should we fund a lifestyle choice?"'

HARRY SHAPIRO

Roger Howard, former chief executive of the UK Drug Policy Commission (UKDPC) pointed out that we needed to understand journalists' priorities to make progress, and the structure of a national newsroom where the reporter taking the story was likely to be different to the headline-writer and picture researcher. The education needed to affect the entire culture of news organisations – a task that had been tackled through UKDPC publications back in 2010. The guidance was still relevant today, and available in an archive at *www.ukdpc.org.uk/publications*



A DIFFERENT BEAT

With punitive measures ineffective in tackling drug problems, senior police are calling for a fresh approach

'The present approach to drugs has almost completely failed. It's costing a fortune to the taxpayer. It's causing a great deal of misery, and we seem to be locked into a pattern of behaviour that we're having a great deal of difficulty escaping from.' David Jamieson, retiring police and crime commissioner (PCC) for the West Midlands told the Drugs, Alcohol and Justice Cross-Party Parliamentary Group of the growing successes of his region's approach, which had focused on 'reducing crime, reducing harm, but also reducing the cost of crime'.

'Every three days somebody in our area was dying of drug poisoning – needless deaths of young people and again misery for the families,' he said.

Eight recommendations had been taken forward from a summit held in 2018, with the aim of spending more effectively to reduce harm (see box). One of the best measures to be put in place, he said, was working with Cranstoun on the Divert programme – referring people with small amounts of class A drugs in their possession into treatment instead of introducing them to the 'costly and damaging' criminal justice system.

There was 'more of a system approach' now to giving people an alternative to custody, explained Megan Jones, West Midlands PCC's head of policy, with multi-agency teams working with offenders and families. The success stories in rehabilitating prolific offenders had earned support and investment from the business community and the three family courts were resulting in much more positive outcomes.

Colleague Til Shaw added that the initiatives to engage with people in custody were proving effective, working closely with probation and courts to increase requirements for alcohol treatment and drug rehabilitation, which were reducing reoffending rates.

The next step was to tackle the root cause of drug and alcohol problems and provide wraparound services, including housing and mental health support, she said, as well as looking at what they could offer for under-18s.

The pre-arrest diversion scheme was an extremely valuable way to enhance young people's opportunities, explained Dan Gordon, also from the team. More than 500 young people – most of whom were in possession of cannabis – had been referred in the first three months, and further initiatives were underway to tie schemes to education, to prevent exclusion from school.

Diversion was a 'key component' to doing things differently, said Jason Harwin, deputy constable of Lincolnshire Police and National Police Chiefs Council lead for drugs. 'It's not just about enforcement – far too many people are dying from illicit drugs on our streets,' he said. 'We need to be doing something different and recognising that police are part of the solution... we don't want to criminalise people.' The way forward was to get people into services quickly, which would also contribute to making the wider community safer.

There were an estimated 300,000 registered heroin and crack users according to PHE, but these numbers were not representative because criminalisation hid drug use away, said Jason Kew, chief inspector at Thames Valley Police. 'That creates stigma and stigma kills. We need to do something about this now,' he said.

This involved re-evaluating the role of policing in relation to possession, particularly where the threat of arrest was not acting as a deterrent. Young people, particularly between the ages of 16 and 24, were going to take risks, 'like we all did'. The situation called for us to 'be honest and take a public health approach to keeping people safe'.

The other key point was that drug services tended to see the people with the most 'problematic' drug use, 'but we need to work out a way of reaching people drug services don't normally see' – the people who were living with or developing drug use, who weren't known to any services.

With the highest rate of drug-related deaths on record and as home to a third of the drug-related deaths in Europe, the UK needed to 'look at drug policy differently and urgently, and create ways to avoid stigma,' he said.

We had an academic evidence base and the tools for a 'humanist health-based approach' to work in a trauma-informed way and offer help instead of arrest, he said. We needed to be 'bold and brave' and work smarter, to put the proceeds from crime back into health. **DDN**

RECOMMENDATIONS

1. Diverting people away from the criminal justice system
2. Regional Drug Interventions Programme (DIP)
3. Heroin-assisted treatment
4. Drugs early warning programme
5. Safety testing of drugs in night time districts or festivals
6. Naloxone provision
7. Drug consumption rooms (DCRs)
8. Taking money from organised criminals to improve drug services

'When I scribbled my first 30 days in my journal, the language was quite frankly appalling and even I struggled to make sense of the spelling when reading it back. But at the time it provided relief and purpose, which is what mattered the most.'

WRITE IT DOWN!

Keeping a journal can be an indispensable recovery tool, says **Darren Taylor**

As we exit one of the most stressful periods of a generation, my mind flits between the success of having stayed calm and sober and how I managed to write a book whilst juggling working from home and home-schooling. When considering the surrounding mayhem, I'm drawn to the conclusion that having such a focus was key in helping me manage the added stress and keeping me from turning to alcohol – my former coping mechanism.

When we are stressed it affects thought processes such as concentration, planning and judgment. This can make you lose focus on recovery, so keeping calm where possible has been beneficial since I quit drinking in 2019. Being stressed, I discovered, was one of the main relapse traps for me, and so it was imperative that I had this in mind throughout the pandemic.

Having used writing as a tool to keep focused in my day job, I took to journaling about my sobriety right from the beginning and credit it as a major contributing factor to my success. My first written 30 days, while a grammatical calamity, tell a compelling story of what goes through someone's mind once they quit drinking. Not only that, but the effect on family members, the cravings, and the all-round change of perspective. Reading these thoughts back, I could really take note of valuable lessons learnt from agitation, guilt, exercise, moderation, avoiding situations and searching for contentment.

Armed with this knowledge, my experiences from a four-year stop-start battle with binge drinking, and an understanding of what worked for me, I hoped I had the foundation to help others. From this, my initial idea of publishing a self-help journal and my book *Finding Your Sober Bubble* were born. With lockdown providing an opportunity to switch focus by channelling my efforts to produce it I suddenly had an alternative coping strategy.

Emptying my brain of all the bits 'flying around' in there relieved some of the tension that we all carry around in our everyday lives. In turn this worked as further personal inventory work, one of my key takeaways from AA's step four. Seeing the book develop helped me increase mindfulness in terms of perspective, and kept me focused on the goal of being able to publish something that may be of use to others in similar situations.

Writing the book also presented an opportunity to connect with my inner self and increase self-confidence by going over which aspects of my sobriety journey I had found effective and which I had not, reinforcing how I would continue to manage adversity and change as I grew stronger in continued sobriety. Along with reduced stress, writing down our thoughts is proven to be beneficial to our memory function, boosting our mood and supporting overall emotional health. This is certainly the case for me as it prevented me losing focus and falling into some of the common relapse traps such as boredom, losing motivation, negative thought escalation and resentment.

You may know that the more time you spend thinking about drinking, or not distracted from the thought of drinking, the stronger cravings can become, increasing the chance of relapse. By writing my journal and book I was able to flip this on its head and reduce the risk.

My advice to anyone looking for a coping strategy is that writing or journaling is up there with the best, and I would encourage you to give it a go. You don't have to go as far as publishing a book for it to help – in fact, when I scribbled my first 30 days in my journal, the language was quite frankly appalling and even I struggled to make sense of the spelling when reading it back. But at the time it provided relief and purpose, which is what mattered the most. What you write is there to help you alone. Using the analogy of a shopping list, it just takes the pressure off having to remember what you need, and writing your thoughts down is no different. Both ease up some much-needed hard drive space, something that is beneficial as you become occupied with the task-in-hand – not drinking.

So, whether you can just about spell, prefer to doodle, or have a fully formed novel bursting to get out, start by keeping a journal. Make it personal, and for some of you I'm sure, keep it private. It worked for me.

Finding Your Sober Bubble and The Sober Bubble Early Discovery Journal are available on Amazon. Darren's website is soberbubble.com

GENTLY DOES IT

Simply cutting off the supply of benzodiazepines to people who've been prescribed them for years is far from appropriate, says **Bill Nelles**

Winter is almost over, but here in Qualicum, British Columbia (BC), we tend to be like the animals around us. We hibernate from November until mid-March, when we hear the roar of the tree frogs calling out for mates in our local pond.

We have a saying here, 'Don't poke the bear' – aside from its obvious meaning as a wilderness warning it also means avoiding a discussion of something that is controversial and likely to end in arguments. I heard this expression for the first time last year on a Zoom call with the BC Provincial Opioid Task Force. Benzodiazepine (BZ) policy for people on opioid agonist treatment (OAT) was on the agenda but time was running short. As we moved to the last item one of my colleagues drily observed, 'I'm not poking the bear when there's only 20 minutes left'.

The bear here is, of course, prescribing benzodiazepines to people who are on opiate agonists for their opioid use. So I'll start with three clear statements: benzodiazepine use increases drug-related poisonings and mortality when taken in quantity with alcohol or opioids; these risks start to increase as you get older, so avoid excessive use; and, it is reasonable for doctors to decrease your dose.

And sincere congrats if you have done the stopping or helped someone else to do this.

But things can go too far. Four years ago we adopted a strict no benzo policy – actually prohibition – for people on OAT in this province. Doctors face serious misconduct proceedings for stable dose prescribing except in end-of-life care, and prescriptions are reviewed through a real-time network called Pharmanet so concurrent prescribing is flagged. Only tapering is permitted, as long as it is reasonably fast. This policy came in rather suddenly, and some doctors have tried hard to contain the deep distress that this caused to many patients.

But the key word here is excessive. For more than 50 years, BZ drugs have been a much safer alternative to barbiturates and other stronger sedatives. Taken on their own, they are remarkably safe. And they were often thrown at users – and I do mean scripts thrown across the doctor's desk – as 'shut-up' pills by doctors who wouldn't provide OAT.

It's also been forgotten that BZ drugs are specific anti-anxiety and hypnotic medicines. They are not anti-depression drugs like SSRIs, although these have now become the 'go to' drugs for anxiety, which is not quite the same as depression. More problematic is the use of atypical anti-psychotics such as quetiapine 'off-label' as hypnotics, despite the manufacturers' warning that they should not be used as sleeping medications.

Some of you will already have read about a programme in Scotland to provide access to genuine benzodiazepines as 'safe supply', led by no less a figure than Professor Roy Robertson – widely known as the Scottish doctor who, in a seminal study in the *Lancet* in 1985, alerted the UK to the high levels of HIV among injecting drug users in his Edinburgh practice. I think this is a reasonable response to current circumstances, but we can't do it here – yet.

I can live with a policy of reducing their use in general, but people prescribed these drugs for years who cannot live without a small amount should not be cut off. By all means don't start people on them, but have a care for those who cannot stop them and who are now purchasing toxic fakes instead. Absolute bans are rarely appropriate, tempting though they may be. Leave some wiggle-room for those who are suffering and avoid our approach.

> 'We have a saying here, "Don't poke the bear" – aside from its obvious meaning as a wilderness warning it also means avoiding a discussion of something that is controversial and likely to end in arguments.'

Bill Nelles is an advocate and activist, now in Canada. He founded The (Methadone) Alliance in the UK

Illustration: JellyPics

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VIRTUAL REALITY

Strategic planning took a different format this year but was just as effective, says **Liane Taylor**

Humankind's senior management team have recently harnessed online technology to deliver a virtual residency for two days. In previous years, the residency has been held at a central location to plan the way forward. Obviously we couldn't meet up physically this year, but as this event is critical to the ongoing success of the charity, we decided to hold it online.

Our organisation believes that holding a senior management away day is beneficial for three reasons. Firstly, it's important for leaders to build time into their schedule to reflect, think and plan as a group. Secondly, to ensure quality and impactful services are delivered successfully, leaders need time to discuss and debate proposals to ensure we choose the best way forward. Finally, by getting away from the office, management have the time and space to enable innovation to flourish, which is essential for future success.

We use the residency as a time to reflect on the last year and discuss, debate and agree on how to provide better, more impactful services in the future.

Using online software to facilitate learning, team members held conferences and smaller break-out groups to discuss topics including strategic vision, service integration and how to embed the use of digital technologies across service areas. Equality, diversity and inclusion were central themes and the group explored how Humankind can embed these principles in all areas of work.

Over the two days, we had time to reflect on what a massive year this has been for everyone and to acknowledge our talented, creative and hard-working staff teams who have supported the people who use our services to achieve so many things, all during the extremely challenging backdrop of a global pandemic.

I came away with a renewed sense of energy and purpose and excitement for what is to come for Humankind. I'm looking forward to working out how we share this further during our workforce roadshows coming up in April and for away days for teams right across the organisation.

Liane Taylor is lead director of integration, housing and strategy at Humankind

abluecup / iStock

A QUESTION OF SUPPORT

Richard Snaith's enthusiasm for online quizzes has kept service users from loneliness in lockdown

I began compiling quizzes to help ease loneliness and to afford people using the service some lighter moments during lockdown, and have prepared more than 300 in the last 12 months.

With all the changes we've had to make to service delivery and the fact we knew isolation was a big issue for people over the past year, we started doing lunchtime social sessions. They are basically an hour where our members can log onto the Zoom session, take part in the quiz and have a chat.

> 'I've learnt so much about people that use our service and I've been able to be there for them on both the good and the bad days.'

It was tricky at the start to organise quizzes as most people had not heard of Zoom. So for the first couple of months it was all about working with people to set it up and them knowing how to use it.

It's been a gentle way to introduce people to new technology – I know some participants now hold Zoom sessions with their family after they have learnt how to do it from our lunchtime sessions.

Holding and organising these quiz sessions has been amazing, insightful and a privilege. I've learnt so much about people that use our service, and I've been able to be there for them on both the good and the bad days.

From the start I set out to make the quizzes fun and inclusive – it's all too easy to just make the hardest quiz in the world and no one enjoys them. There have been plenty of amusing incidents – we've worn masks and hats, and we even have singing rounds. We also had a dancing round before Christmas where people got extra points if they could show the group their dance moves.

While hoping the restrictions on people's movement will soon end, I'm determined to continue. So many people have benefitted from these events it would be a shame to stop now – I just need to keep coming up with the questions!

Richard Snaith is an early intervention and prevention worker at Humankind

REACH OUT

Amy Lucas describes how Reach Out, Forward's live chat service, has grown from an emergency pandemic response into a valuable safety net

Nearly a year ago, on 1 May 2020, Forward launched its first ever live-chat service: Reach Out. Plans for such a service had been in the works for a while, but accelerated dramatically when the pandemic hit. We were mindful that a lot of vulnerable people – both our current service users and those not getting help but struggling – would be looking for sources of support at what was an incredible lonely and anxious time, and Reach Out seemed to be one small way in which we could help.

It took a while for people to learn about the service, but – with funding from the National Lottery's Coronavirus Community Support Fund and J Leon Group to help with marketing and promotion – it has become increasingly popular, and we've seen a 500 per cent growth in call volume since November.

Although Forward delivers a range of different types of support, including employment and housing, we're most well-known for our drug and alcohol services, so we thought the vast majority of people contacting us would be doing so to chat about issues with substances. And, to begin with, they did.

However, in the course of the last year we've had an increasing amount of people getting in touch due to mental health issues, and these now form a significant proportion of the calls we receive – 60 per cent in total. Lockdown has, of course, been a driver in people wanting to reach out, but the biggest thing we've noticed is people getting in touch because they had no-one to talk to. We're helping people who are really quite lost and, although that's a big responsibility, it's also a huge privilege to know that we can be a source of support and comfort.

Reach Out is run by a team of Forward staff and volunteers who have given up time from their normal roles to become 'agents' for the service. One of the amazing things is that it's not just callers who have benefitted from the service, but our staff – many have told us that, in addition to the satisfaction of knowing they're helping people, volunteering for Reach Out has helped them to hone their skills and knowledge base. This has been particularly important for frontline staff whose interaction with clients has been severely limited in the past year. For everyone involved – whether the people in touch or the amazing team at the end of the line – Reach Out has served an incredibly important purpose.

As one agent, Samantha Daly, Connections family support worker at HMP Standford Hill, says, working on the service has been 'incredibly rewarding – the team as a whole is very supportive and I feel very lucky to be a part of it. We all have important skills that contribute toward creating this very unique, virtual support system that is Reach Out. I have supported people with a wide range of issues – from mental health to worries about a loved one, from drug and alcohol advice and support to working in partnership with other organisations and agencies who want to refer clients. Reach Out has helped me embed key skills and enhance my empathic listening and responses to real life situations, and I'm truly grateful to have been given the opportunity to do so.'

We've been really lucky to have had some fantastic support from other organisations in the field who were experienced in running an online live-chat service, particularly We Are With You, who have been an invaluable source of advice and guidance, and Change Grow Live. It's been a wonderful example of how we in the sector can work together to achieve great things, and we're really excited about the future!

Amy Lucas is Reach Out service coordinator at The Forward Trust

THE STATS

- **60 per cent** of calls to Reach Out are related to mental health
- **87 per cent** of callers are simply looking for someone to talk to
- Since the service opened it's received **2,382 calls** – 517 in the first five months and 1,865 in the following five months, a growth of 360 per cent.
- **27 per cent** of calls in February 2021 were from people who had never engaged with The Forward Trust but were looking for advice and help

'I was just getting to the point where I was about to lose it emotionally at work and needed to do something about it – thank you'

'Honestly I cannot thank you enough. I can't describe it but I feel so much better just talking this out with you today'

'I prefer this kind of set up – talking on the phone about this. In fact, just saying the words out loud is a struggle. It's much easier for me to write them down'

'I'm so grateful for this information, I really didn't know what steps I should take. That little chat means a lot, thank you so much'

Everett Collection / Dreamstime.com

In it together

Behavioural couples therapy for alcohol dependence can both strengthen relationships and reduce problematic drinking, says **Kate Thompson**

Although behavioural couples therapy has been recommended in NICE guidance since 2011 for 'harmful drinkers and people with mild alcohol dependence who have a regular partner who is willing to participate in treatment', counselling and therapy that focuses on the couple and parental relationship has never formed any significant part of the alcohol treatment service landscape.

In 2009 Tavistock Relationships was commissioned by the NHS to develop a couple-based treatment for depression – known as couple therapy for depression or behavioural couples therapy – a talking therapy which year-on-year achieves some of the highest rates of recovery from depression and anxiety within IAPT (improving access to psychological therapies) services nationally. So, when the 'children of alcohol dependent parents' funding stream was announced by the Department for Health and Social Care in 2018, we were keen to take on the challenge of delivering training to practitioners in behavioural couples therapy for alcohol dependence (BCT-AD) to see whether this treatment could be introduced and embedded into existing treatment services.

To this end, in 2019, Tavistock Relationships delivered a total of three sets of training – in Leeds, Bristol and London – to 29 practitioners from a range of professional backgrounds including counsellors and drug and alcohol workers. We then supervised these trainees as they set about identifying suitable couples experiencing alcohol dependence who would become their 'training cases', over a period of eight to 12 months.

'In 2019, Tavistock Relationships delivered a total of three sets of training – in Leeds, Bristol and London – to 29 practitioners from a range of professional backgrounds including counsellors and drug and alcohol workers.'

‘Some practitioners found it was difficult to identify couples who were suitable for this approach... more commonly, because the alcohol treatment service simply wasn’t set up or commissioned to work with couples.’

PLAYING TO STRENGTHS

As with couple therapy for depression, a basic premise of BCT-AD is that the strengths of the couple relationship can, wherever possible, be utilised as a resource to enable positive change, leading to either improvement in mental health or reduction in dependence on alcohol. The model also explores with the couple the possible functions of the drinking within their relationship and what it enables and disables between them. By reducing damaging interactions, BCT-AD aims to build emotional openness and closeness between the couple, improve communication and behaviour, and help the couple cope with the ordinary and not-so ordinary stresses that arise without such a high degree of dependence on alcohol.

So, how did our trainees get on? And to what extent can we feel confident that we have made inroads into changing the way that people in alcohol treatment services are treated? All practitioners on the training recognised that this way of working addressed a gap in their expertise, and while changing the focus of their work to think about the couple relationship presented a number of conceptual and practical challenges, the practitioners were all very positive about what was essentially a new way of working to them. So far, so good.

DIFFICULT DELIVERIES

The difficulties that our trainees faced in actually delivering BCT-AD to clients subsequent to the training, however, were many and various. The pandemic didn’t help matters, of course, with some trainees finding couples that they had begun to work with face-to-face not wanting to continue their sessions via Zoom, and some services simply not being able to function during the lockdown periods.

Some practitioners found it was difficult to identify couples who were suitable for this approach – either because the assessment process unearthed issues around domestic violence which would have made delivering this therapy too risky – or, more commonly, because the alcohol treatment service simply wasn’t set up or commissioned to work with couples. As we progressed, service managers began to identify important sources for future referrals, such as social care or probation services, but needed more time to establish these.

Additional challenges included the precarious nature of the services in which the alcohol practitioners were working, with funding being withdrawn from many and several subsequent redundancies or resignations among the cohort of people that we trained, as well as the relative lack of clinical training for practitioners working in this sector. Taking on board and incorporating skills around working with couples presented a significant issue for some trainees – as one of our supervisors observed, many felt that such was the focus on the individual within their services that they had to effectively generate a completely new pathway to make a success of this new way of working.

EMOTIONALLY CLOSER

On the positive side, many BCT-AD trainees have found that the couples they worked with benefited from this approach. One couple, for example, said some way into the therapy that their sexual relationship had resumed as a result of the work they were doing together (they had been too ashamed to admit it had been nonexistent before), their depression and anxiety had reduced, and they were finding space and time to do things together as a couple. According to practitioners, other couples became emotionally closer and more open and more empathically attuned to one another, calming the atmosphere at home – which their children had begun to notice.

NEW CHALLENGES

In conclusion, this pilot project was positive, but presented services and practitioners with challenges, and it’s too soon to say how successful the project’s ambition to provide an alternate way of reducing alcohol consumption by improving the couple relationship has been. We are buoyed by the fact that while the alcohol treatment service of one of our trainees was decommissioned during the time period of this project, that person is now working in the NHS as an addictions practitioner helping to design services for people with dual diagnosis and has ambitions to include behavioural couples work in that service’s care pathway. So the legacy continues, albeit in a small way, and we hope that more services will appreciate the value that working with couples can bring to the lives and experiences of people struggling with alcohol dependence.

To find out more about this project and about behavioural couples therapy for alcohol dependence, contact Kate Thompson at kthompson@tavistockrelationships.org

Kate Thompson is couple psychotherapist at the Tavistock Centre for Couple Relationships

POSITIVE OUTCOMES

One therapist described the impact of the therapy on a couple, and on one partner’s drinking in particular:

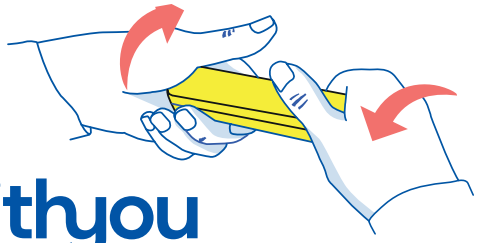
‘I think that behavioural couples therapy for alcohol dependence has provided this couple with a space to talk and think together about the male partner’s drinking, the impact it has on their relationship and how what goes on between them might be contributing to patterns of behaviour that neither desires or enjoys. Since starting therapy, the male partner’s AUDIT score has dropped by a third (24 to 16), and his GAD7 [generalised anxiety disorder] and PHQ9 [depression] scores have also reduced. I think this reflects both an actual decline in alcohol consumption, and a difference in how he fills out the form – in the early sessions, the male partner tended to score himself very highly, including recording a “5” on a question with a scale of 1-4! We were able to think together about why he might be doing this, including his belief that he was “bad” and might need to be “punished”. Perhaps significantly, the female partner’s PHQ9 measure has risen slightly, perhaps because now she no longer thinks of her partner, or of his alcohol misuse, exclusively as the “problem”, it feels safer for her to be more in touch with some of her own difficulties.’

Another therapist noted that, after around nine sessions, the therapy had resulted in both a reduction in alcohol use and in the level of distress in the relationship – an outcome the therapist was pleased, even surprised, to see, given her experience of working in alcohol services, and how difficult and lengthy the process can be of helping people with alcohol dependence to change.

Online advice and support on safe injecting

With You have launched new online support for safe injecting. Get advice and guidance on using drugs more safely or use our finder to find a needle and syringe service or pharmacy near you.

Visit **wearewithyou.org.uk/safer-injecting**



withyou

TENDER NOTICE

Suffolk County Council

Suffolk County Council are in the process of engaging with the detox and rehab sector ahead of a forthcoming tender process.

The current arrangements for Suffolk residents who require access to inpatient detoxification and residential rehabilitation facilities is due to cease on 31st March 2022.

To inform the new arrangements, Public Health Suffolk are keen to engage with the sector to help shape a new service specification.

Details of the tender process will be published later in the year and will be advertised on ***www.suffolksourcing.uk***

In order to help us shape a specification, we value input from as many organisations as possible. Our survey can be found at: ***www.drinkanddrugsnews.com/suffolk-cc-tender-notice/***

Forward

Are you interested in changing people's lives and supporting lasting recovery?

Are you in recovery yourself with lived experience?

We are interested to hear from people who want to make a difference to people's lives, people who may or may not have lived experience in recovery, or as a family member of someone in recovery.

We are currently recruiting for:
- Psychotherapists
- Drug and Alcohol Practitioners
- Team Leaders
- Recovery workers
- Substance Misuse Nurses
- Apprentices & Volunteers

We offer:
- Competitive salary
- Simplyhealth cover
- Childcare vouchers
- Therapy allowance
- Career development
- Up to 30 days annual leave

View our current vacancies at
www.forwardtrust.org.uk/work-for-us/

THE HEPATITIS C TRUST

PASSIONATE PEER WORKERS WANTED

The Hepatitis C Trust is expanding its network of peer workers across the country and will be looking to recruit up to 20 new staff to join its team before the end of the year. As the UK's charity for hepatitis C patients, and a leading player in national efforts to eliminate the virus, The Hepatitis C Trust has proven the role of peers in engaging those who meet the most challenges in accessing services.

The Hepatitis C Trust will be seeking passionate and skilled peer leads with excellent communication, engagement, and organisational skills to be part of a history making journey to eliminate the virus. Experience of working within drug services and with volunteers, having been affected by hepatitis C or having supported someone who has hepatitis C are all desirable if you feel that you or someone you know may be interested.

DDN will be hosting a series of job adverts with details of how to apply over the coming months so please look out for an opportunity in your area.

www.drinkanddrugsnews.com/jobs

Superstars wanted!

WDP has been transforming lives for over 30 years & we help thousands of people each year improve their health and wellbeing. Working together, we make sure that our service users get the help they need & we support them every step of the way.

Our people are at the core of what we do.

We invest in and empower our people to grow and develop in a nurturing and rewarding workplace.

As an inclusive and diverse community, we are always seeking people from a variety of backgrounds, cultures, ages, experiences, and identities to join us. We welcome applications from under-represented and intersectional groups and persons with disabilities.

As part of our commitment to overcome unconscious bias and further promote diversity we are pleased to announce that we now practise fully blind recruitment to ensure that we get closer to achieving equity with every single application received.

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